The Multilingual Videotape Project: Community Involvement in a Unique Health Education Program

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Synopsis

The large number of Southeast Asian, Hispanic, and Portuguese immigrants in Rhode Island face formidable language and cultural barriers in gaining access to the health care that they need.

As the funding for refugee-specific programs diminishes, the focus is on programs that encourage self-sufficiency, assist in gaining access to mainstream health care, and involve a collaboration among service agencies and the communities they serve.

On behalf of a coalition of health care and community agencies, Women and Infants Hospital of Rhode Island received a private foundation grant to produce nine multilingual videotapes that would educate immigrants and refugees about health issues specific to them and help them access the health care system.

The project was structured to maximize the involvement of the various communities and to "empower" community members in working with mainstream service agencies. Coalition and other community members provided input into topic selection, script content, and presentation methods for the videotapes that would be culturally appropriate.

During the 2-year project, nine videotapes were produced with narration in seven languages. Copies of the videotapes were distributed free of charge to coalition members.

RHODE ISLAND, with a population of 988,609 (*1*), has long had a tradition of ethnic and cultural diversity, and in the past decade the State has welcomed a large number of Southeast Asian, Hispanic, and Portuguese immigrants and refugees.

Since 1975 an estimated 14,000 Southeast Asians have taken residence in Rhode Island, including 2,394 Hmong, 4,570 Laotians, 6,660 Cambodians, and 500 Vietnamese (*2*). In 1987 there were 20,000 to 22,000 Hispanics documented as living in Rhode Island, although a more accurate number that includes illegal aliens may be as high as 35,000 (*3*). The Portuguese community in Rhode Island includes both families that have lived there for generations, and more recent arrivals—almost 1,000 Cape Verdeans and several thousand Portuguese arrive in the area every year. An estimated 20,000 Rhode Islanders still hold Portuguese passports (*4a*).

While these numbers are useful in understanding the size of Rhode Island's immigrant population, they give no indication of the diversity among the various groups. For example, each of the four Southeast Asian groups have separate languages and differences (as well as commonalities) in cultural practices, religious beliefs, and health care beliefs (*5*). Members of Rhode Island's Hispanic communities come from 23 South and Central American countries and Caribbean islands, each with their own economic and social conditions (*4b*). In addition, within a population from any given Southeast Asian, Latin American, or Portuguese-speaking country, there are a myriad of differences among people with respect to socioeconomic backgrounds, educational levels, familiarity with the United States health care system, and family situations (*6*).

Despite the differences among the refugee and immigrant populations, these groups share certain health problems to some extent—tuberculosis, hepatitis B, and sexually transmitted diseases (*2*), problems with prenatal and perinatal care (*7,8*),

and lead poisoning (*9*). But perhaps the most vital health care issue for many new immigrants and refugees is the difficulty they face in accessing mainstream health care services because of language and cultural barriers.

Trends in Program Funding

Providing these diverse populations with health care services appropriate to their needs continues to be a challenge, particularly as program funds for these individual groups are diminishing or inadequate to begin with.

While Southeast Asians (SEAs) have received refugee assistance over the past 10 years, as the number of refugees entering the United States decreases, Federal funding has diminished (*10*). Yet the decrease in SEA arrivals in the United States does not accurately reflect the situation in Rhode Island where the total number of SEAs has more than doubled from 6,600 in 1984 to 13,900 in 1989 via "secondary migration" from other States as people join family members or seek job opportunities (*2*). In addition, many of the later arrivals to the country have been less educated and less familiar with medical basics and Western health care practices (*6*) and thus need more assistance in accessing health and social services.

Rhode Island's Hispanic and Portuguese populations are not eligible for programs directed toward refugee resettlement. Hispanics are considered members of a minority population, not refugees, while illegal aliens are not eligible for any government assistance. Portuguese immigrants are not considered either refugees or minorities (*4c*). These groups, however, like the SEA population, face similar language and cultural barriers to accessing health care and other mainstream services.

Thus health and community agencies face the challenge of meeting the needs of an increasingly large and heterogeneous immigrant and refugee population with a decreasing amount of Federal and private funding. Those in control of the funding recommend that agencies focus on programs that promote self-sufficiency and facilitate access to appropriate mainstream services by addressing language and cultural barriers (*10*).

Community Empowerment

Collaboration between health and human service agencies and the community-run agencies that represent the people they serve is a way to achieve these goals (*4c*). Coalitions can be more than simply a cost-effective means of sharing resources and distributing health care information. The involvement of a community in the design and implementation of its own health care services can contribute to a sense of "empowerment."

Community empowerment can be defined as a process of increasing control by groups over consequences that are important to their members and the broader community (*11*). The empowerment process is further characterized as "an interactive process, involving mutual respect and critical reflection, through which both people and controlling institutions are changed in ways that provide those people with greater influence over the forces that are influencing their efforts to achieve or maintain equal status in society" (*12*).

In addition, "because health behaviors are culture-bound, primary prevention efforts that address preventable disease and illness must emerge from a knowledge of and a respect for the culture of the target community to ensure that.. any interventions that emerge are culturally sensitive and linguistically appropriate" (*13*). Because the involvement of community members will help to ensure that the services are designed to address *the needs of the community as perceived by that community*, rather than as perceived simply by the providing agency, the resulting services likely will be more relevant and accessible—and thus more acceptable to the community. The accessibility of health services has been shown to affect the health care behavior of minority groups (*14,15*).

The Multilingual Health Care Coalition

In 1985, the major health care providers serving the Southeast Asian and Hispanic communities in the Providence area conducted a series of focus group meetings with leaders from both communities. The goal of the meetings was to discuss issues of mutual concern and the possibility of collaborating on projects that would benefit both ethnic groups. The Multilingual Health Care Coalition, consisting of three hospitals, one community health center organization, and the two ethnic groups, was formed as an outgrowth of these efforts.

In 1986, the coalition received a $100,000 grant from the Rhode Island Foundation and the Prince Charitable Trust to support a collaborative project that resulted in the production of nine 15-minute videotapes and the translation of these tapes into six languages in addition to English.

The videotape approach was chosen for several reasons. Tape could demonstrate procedures and

concepts that might be difficult to explain or translate in print. Tape could circumvent the problem of illiteracy, both in English and in the viewer's own language. In addition, all of the health agencies involved owned video cassette recorders (VCR) for patient and community education, and community groups reported that a large percentage of their people owned VCRs. Initial discussion with community leaders also determined that videotapes were commonly used in the immigrants' own countries both by the government and for communication among family members.

Health care agencies in the coalition serve large numbers of immigrants and refugees. Some 60 percent of the infants born in Rhode Island are delivered at Women and Infants Hospital of Rhode Island, the institution that spearheaded the coalition and administered the videotape project. Members of the immigrant community were officially represented in the coalition by two groups already in existence. One group was composed mostly of Hispanic social service agency personnel. The other group was formed to consolidate the four Hmong, Cambodian, Laotian, and Vietnamese Mutual Assistance Associations when Federal funding for these individual agencies was drastically reduced.

In addition to these "official" coalition members, input was sought from many community leaders, health care clients, community members working as bilingual translators in the health and human service fields, and health care workers with experience in providing direct patient care to these populations.

In order that some of the grant funds could be returned to the community, 18 translators and narrators were hired for the videotape project. The people chosen were actively involved in their communities—most worked as bilingual staff persons in the health care field.

Input Into Tape Content

Coalition members selected and prioritized health care topics to be covered in each videotape, according to what they considered to be the most pressing issues for the refugee and immigrant communities. The nine topics chosen for the videotapes were an introduction to primary care, an introduction to the hospital, hepatitis B, tuberculosis, sexually transmitted diseases, prenatal care, well newborn care, discharge instructions for new mothers, and lead poisoning.

Each tape would be narrated in English, Spanish, Portuguese, Cambodian, Hmong, Laotian, and Vietnamese. While the ideal situation would have been to produce entirely different videotapes for the SEA and Hispanic audiences, budget and time constraints did not allow for this. Coalition members were able to reach a consensus, however, on topics to be covered, and culturally sensitive issues raised by members were addressed within each tape.

The first two videotapes, entitled "A Visit to the Doctor," and "A Visit to the Hospital" were intended to increase the viewer's ability to understand and access the health care system, thus increasing confidence in seeking health care and making health care decisions. Because many SEAs and Hispanics place a low value on preventive care (*6,16a*), the "Doctor" tape focused on the need for primary prevention. In an attempt to allay the fears that many SEAs have about hospitals and surgery (*17*), the "Hospital" tape described basic hospital procedures, the roles of hospital personnel, and surgery.

In both tapes, patients' rights were emphasized, including laws requiring health care facilities to obtain the informed consent of patients and to provide interpreters for them as well as the importance of patients participating in decision making regarding their own health care. Both tapes also discussed insurance payment systems and the right of all patients to receive necessary health care regardless of their financial situation.

These first tapes are most helpful to new arrivals with little or no experience with the health care system and are viewed by them at health care centers where all immigrants must go upon arriving in Rhode Island. These introductory tapes are also used in community group meetings and at agencies that sponsor and assist recent immigrants.

The second series of videotapes covered three health care problems considered by members of the coalition to be top priority for Rhode Island immigrants and refugees—sexually transmitted diseases, tuberculosis, and hepatitis B. The prevalence of these problems among these communities is cited in the literature (*15,18,19*). Although there has been little documentation of sexually transmitted disease among SEAs in Rhode Island, several SEA community leaders expressed grave concern that their people were assuming a more Western philosophy of "freer" sexuality, yet had little or no concept of the transmission and consequences of sexually transmitted diseases, including AIDS.

Upon reviewing a script draft, however, a Laotian leader stated that he was uncomfortable with the explicit discussion of modes of transmission. At

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the same time, a leader in the Hispanic community expressed disappointment that the script was not more explicit. Although the ideal solution to the dilemma would have been to produce two separate videotapes, time and budget limitations did not allow for this option. A consensus was reached among coalition members, translators, health care providers and community members that the script should remain as explicit as it was to explain disease transmission and prevention, but that if it was any more explicit, it might offend some viewers.

Through these discussions it was also decided that people who received the STD videotape would sign a written agreement stating that they understood that the tape contained explicit material, and that it was to be shown only on a one-to-one basis with a health care provider available to answer questions. Agencies that received these tapes have willingly signed this agreement and have not expressed reservations about restricting its use. In addition, in an evaluation survey, four out of the five respondents who use the STD tape with their clients rated the usefulness of the final tape as either "good" or "excellent." (One respondent left this answer blank).

The third series of tapes was devoted to basic prenatal care, newborn care, and care of new mothers. A variety of problems surround prenatal and perinatal services for SEA and Hispanic families, ranging from difficulties with accessing the health care system to differences in beliefs concerning pregnancy, delivery, and newborn care (*20,16b,15,8*).

Members of the coalition felt strongly that tapes produced on these topics should explain the rationale behind such concepts as prenatal visits and pelvic examinations (which many Hispanic and SEA women find particularly embarrassing), prenatal nutrition, hospital deliveries, breastfeeding, and caring for the umbilical cord.

The ninth tape was on lead poisoning. It has been found that the rate of positivity among SEA children living in high-risk areas was even higher than among non-SEA children (mostly black and Hispanic) living in those areas (*9*). Input from coalition and community members led to strong emphasis in this tape on the facts that a child can test positive for lead and still feel and appear healthy; that a child's hands should be washed often; and that pottery or folk medicine brought from home countries may contain lead.

Cultural Sensitivity

Once topics were chosen, coalition members and other community members and health care providers offered input into each script draft. Members discussed word choice, translatability of particular terms and concepts, and cultural issues. For example, reviewers suggested that a section on prenatal nutrition contain examples of foods particular to each community. In another instance, Hmong community members explained that many Hmong are fearful of blood drawing, in part because they are not aware of the body's ability to replenish lost blood (*17*). Thus the segment on blood tests was expanded to emphasize that the body will replace the blood quickly and that drawing blood is not harmful. Further, showing a full syringe of water being emptied into a spoon illustrated that each syringe holds only a small amount of blood.

The translators and narrators also offered invaluable feedback on the choice of language, clarity of concepts, and cultural acceptability. To give examples, some Western medical terms proved to be untranslatable in certain languages, so translators worked with the project coordinator to develop explanations that would be meaningful to viewers. In other situations, the input of the translators was sought regarding sensitivity issues, such as for the videotape on sexually transmitted diseases.

Videotaping took place at the hospitals and health centers where community members received health care. The health care providers and bilingual persons at these agencies, as well as other community members, served as actors and actresses in the scenes. Many of the "cast" members and the translators commented that participating in the project allowed them to contribute something valuable to their communities.

Distribution

Free copies of each tape were made available to all coalition members in languages they requested—

Scores given to statements by eight respondents in the evaluation survey of multilingual health videotapes, Providence, RI, 1988

Statements	Number assigning grade					
	Poor	Fair	Average	Good	Excellent	Average
Information clear and understandable	0	0	3	3	2	3.88
Language level appropriate for clients....	0	0	4	2	2	3.75
Medical terms explained clearly	0	0	3	2	3	4.0
Video pictures illustrate content	0	0	4	2	2	3.75
Graphics and illustrations effective.....	0	0	1	4	3	4.25
Presentation culturally sensitive	0	0	2	2	4	4.25
Ethnic groups adequately represented ...	0	1	0	1	6	4.5

a total of 378 tapes. In addition to the original coalition members, some 25-30 other health and community agencies in Rhode Island and other States have requested and received copies of the tapes for a minimal fee (the cost of a blank tape). Translators who participated in the project have also requested and received copies of the tapes to show to family members and friends to help them gain understanding about certain health care topics.

Evaluation

Coalition members and other agencies that have received tapes were asked to return an evaluation survey at the conclusion of the project. Eight agencies responded. In the survey, agencies listed a variety of uses for the tapes. Health care agencies reported using the tapes for clients in clinic waiting rooms, in one-on-one teaching situations, on closed-circuit television systems, and on loan to patients for home use. Several agencies used them to teach medical concepts and terminology to their bilingual staff members. Community agencies reported using the tapes for community meetings, with new arrivals, in AIDS workshops (the STD tape), and with their staff members.

Agencies were asked in the survey to rate the content and quality of the tapes in seven ways on a scale of 1 to 5, with 1 being poor, 2 fair, 3 average, 4 good, and 5 excellent (see table). With one exception, all respondents gave each of the tapes a rating of 3 or higher in all 7 categories. One respondent gave a rating of 2 in answer to the question that asked if various ethnic groups are represented adequately in the tape and added the comment, "not enough Asians." Six of the respondents, however, gave this item a rating of 5, while the remaining respondent gave it a 4. So this category received the highest average score (4.5).

The average score in each category was as follows:

1. Information presented is clear and understandable..... 3.88
2. Language level is appropriate for my clients 3.75
3. Medical terms are explained clearly.. 4.0
4. Video pictures illustrate the content . 3.75
5. Graphics and illustrations used are effective..... 4.25
6. Information is presented in a culturally sensitive manner 4.25
7. Various ethnic groups are represented adequately in the tape 4.5

All coalition members responded in the survey that they would like to be involved in future projects should further funding become available. Future topics suggested by coalition members included mental health, genetics, surgery, prenatal nutrition, and parasites.

It is clear to the authors that the involvement of community members in the development and production of these educational tools has contributed greatly to their usefulness and acceptance within the community. In addition, the project allowed community members to assume a leadership role in the delivery of vital health care information to their people. Members of the initial group continue to work together on numerous task forces and coalitions surrounding issues of health and mental health.

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